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ABSTRACT

Join Together convened a panel of experts to review U.S. policies for addiction treatment and recovery. Although the panel reached an agreement on six recommendations for policy changes that can make help more accessible and expand treatment to more people. These recommendations are: (1) treatment for alcoholism and other drug addiction must be covered as a health benefit on an equal basis with treatment for other diseases; (2) limited access to treatment for alcoholism and drug addiction is a national crisis that calls for a broad-based national campaign to educate the public and build political support; (3) research on the nature and treatment of addiction and recovery should be expanded and the results made accessible to professionals, policymakers, and the public; (4) education and training on addiction and recovery should be required for all health, mental health, social service, and justice system professionals; (5) treatment for alcoholism and drug addiction must be monitored by independent treatment managers with no vested financial interests in order to ensure ongoing treatment effectiveness; and (6) diagnosis, treatment, and long-term recovery must be integrated into a coordinated community-wide strategy to reduce alcohol and other drug problems. One appendix contains a glossary of treatment terms, and the other is a statement from the Physician's Leadership on National Drug Policy. Forty-five treatment resource organizations are listed. (SLD)

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Treatment for Addiction

Advancing the Common Good

Recommendations from a Join Together Policy Panel on Treatment and Recovery

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JOIN TOGETHER

UD 032 752

Join Together National Policy Panel on Addiction Treatment and Recovery

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Dear Colleague:

As a physician and as a former president of the American Medical Association, it was a welcome challenge to chair a national panel to review our nation's policies for addiction treatment and recovery. I thank my colleagues on the panel for their integrity, focus, energy, and caring, and for their willingness to engage in this critical issue. Together we moved to identify what we felt were key problems and some of the *appropriate* solutions to provide adequate treatment.

We held hearings in Baltimore, Chicago, Detroit, and Portland, Maine, where people in recovery, officials from every level of government, judges and police officers, representatives of health care organizations and treatment programs told us of a need for treatment that was going unanswered, particularly in the public system.

We also heard these same folks talk with conviction about how these communities might put a recovery system in place, with help from health care, government, research, the justice system, and other key institutions.

At federal, state and local levels, vast financial and institutional resources are made available to treat our sick and — when necessary — to support their recovery from chronic, recurring diseases. Indeed, we take pride in our country's health care organizations and the talented care givers who staff them.

With one exception.

Four million persons with the disease that manifests itself in dependence on alcohol and other drugs are left to search for care. They must do this in private and public systems that too seldom connect to the health care and supporting systems that research tells us can reduce their symptoms and return them to their families, jobs and communities. At least one million persons are looking for treatment in the public system and not finding any openings.

Although the panel did not agree on every issue at the outset, it is remarkable how quickly panel members found common ground as we heard from these local and national experts and advocates. We offer the following recommendations for serious consideration by community members, legislators, providers, employers, and others. These recommendations can lead to policy changes that *will make a difference.* They can reduce barriers, make treatment more accessible, join health care to services necessary to sustain recovery, and where necessary, expand treatment to the more than one million persons who are seeking — but not finding — help to end their dependence.

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The Six Recommendations

- **Treatment for alcoholism and other drug addiction must be covered as a health benefit on an equal basis with treatment for other diseases.**
- **Limited access to treatment for alcoholism and drug addiction is a national crisis that calls for a broad-based, national campaign to educate the public and build political support.**
- **Research on the nature and treatment of addiction and recovery should be expanded. The results should be made more promptly and easily accessible to professionals, policy makers and the public.**
- **Education and training on the nature of addiction and recovery should be required for all health, mental-health, social service and justice system professionals.**
- **Treatment for alcoholism and drug addiction must be monitored by independent treatment managers with no vested financial interests in order to ensure ongoing treatment effectiveness.**
- **Diagnosis, treatment and long-term recovery must be integrated into a coordinated, community-wide strategy to reduce alcohol and other drug problems. This strategy should encompass economic development, health and mental health care, the justice system and other key institutions.**

These recommendations will not eliminate addiction. However, they, along with others from earlier Join Together national policy panels, (including the preceding panel on criminal justice), offer a valuable foundation on which communities can fashion their own local strategies for overcoming substance abuse. And these community strategies are the base for mounting advocacy initiatives that can lead the policy debate to change the way we meet substance abuse at local, state and national levels.

We heard recovery described as a process that requires close collaboration among a community's institutions. Recovery is a process that is effective and not only heals individuals but also families and communities. It also saves money and other scarce resources in health care, judicial, workplace and other settings.

Recovery from chemical dependence challenges us, individually and as a society. It challenges addicted people, family, friends, employers, caregivers, public officials. This panel report is not intended to address or resolve every barrier to treatment. But it does present several entry points for public conversation and advancing the issue of adequate and appropriate treatment.

Robert E. McAfee, M.D.

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Treatment for Addiction: Advancing the Common Good

Report of the Join Together Public Policy Panel On Addiction Treatment and Recovery

It is ironic that at a time when science is helping us understand the value and efficacy of treating alcohol and drug addiction, it is as difficult as ever to obtain appropriate treatment. This report offers suggestions on how each of us can take steps to ensure adequate and appropriate addiction treatment and recovery resources in our communities. By doing so, we begin to advance the common good. Although addiction is a serious problem, it is manageable.

It is estimated that 18 million Americans abuse or are addicted to alcohol. Some 12.8 million, or about 6 percent of the nation's population aged 12 and over, have used illegal drugs within the last 30 days.[1] Another 11 million abuse tranquilizers and other psychotropic drugs.[2] Nearly half of Americans report knowing someone with a substance abuse problem.[3] The economic cost of addiction is staggering — it is estimated that every man, woman and child in the U.S. pays nearly $1,000 a year for unnecessary health care, extra law enforcement, auto crashes, crime and lost productivity resulting from substance abuse.[4] The emotional and psychological costs are immeasurable.

Yet no other disease goes untreated to anywhere near the extent as substance abuse. Consider the fact that in Illinois last year, more than half a million people needing treatment for substance abuse were turned away.[5] In San Francisco, a staggering 1,300-1,500 persons addicted to drugs and alcohol are shut out of treatment every day.[6]

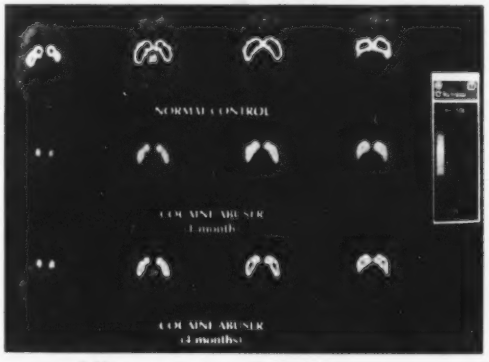
We are in the midst of an urgent, national public health crisis, yet our public policy has failed to respond effectively. Instead, public policy treats substance abuse primarily as a crime. It locks up addicts and tries to block the flow of drugs across our borders. It sees those dependent on, or who abuse, alcohol and drugs as lacking personal responsibility. It ostracizes them, acknowledging no role in either their condition or their cure.

This public policy is severely misguided because it focuses too heavily on cutting supply without also addressing demand. There can be no question that law enforcement plays a critical role in efforts to reduce alcohol and drug abuse. But fighting crime without also addressing its causes is like treading water. No matter how hard we try and how much we spend to stop the flow of illicit drugs, it will continue as long as there remains a demand. By refocusing public policy on

Science has shown us that drug abuse is a preventable behavior and drug addiction is a treatable disease. Drug use is a voluntary behavior, but drug addiction is not—addiction is a compulsive, uncontrollable drug-seeking and drug-use act. Alcohol, cocaine and heroin can all lead to addiction.

Alan Leshner, Director, National Institute on Drug Abuse, Rockville, MD, www.nida.nih.gov

The switch from drug use to addiction is the result of a fundamental and long-lasting alteration of pathways in the brain, as shown by brain imaging technology:



Above photo

Comparative PET scans of a brain characteristic of a cocaine user tested one month and four months after last use of cocaine, compared with a normal control. (Adapted from Volkow ND, et al: Decreased dopamine D2 receptor availability is associated with reduced frontal metabolism in cocaine abusers.)

Synapse, 14:169-177, 1993

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reducing the market for alcohol and drugs, through programs of treatment and prevention, while continuing traditional law enforcement efforts, we will see far greater success. No matter what we may think about people who are dependent on, or who abuse alcohol or drugs, we are wrong to push them aside. Substance abuse hurts everyone, if not directly, then indirectly through higher crime, unnecessary health care expenses, added law enforcement costs, lost workplace productivity and personal and family hardship.

The MOM's Project in Massachusetts is a remarkably effective and innovative program, designed to reduce drug and alcohol abuse among pregnant women. Founder Hortensia Amaro, a professor at the Boston University School of Public Health, and her colleagues have been working to win support for the MOM's Project at the Massachusetts State House. "Our vision is to start a statewide network of mothers in recovery," says Amaro. Last spring, Gov. William Weld declared May 12 as 'Mothers in Recovery Day.' Some 60 mothers were individually recognized for their triumph over addiction before an audience of about 450 healthcare and social service providers, legislators, and other mothers in recovery.

Hortensia Amaro, Ph.D., Professor of Public Health, Social and Behavioral Sciences Dept., Boston Univ. School of Public Health, Boston, MA, 617.638.5160.

The solution to our nation's drug and alcohol problem is for public policy leaders to recognize alcoholism and addiction for what they are — chronic diseases, with biopsychosocial causes and manifestations, whose prevalence has created a public health crisis — and to respond appropriately by making treatment broadly available to all who suffer from these diseases. Such policies would have immediate and far-reaching effects, not only in reducing substance abuse and improving health, but also in making our communities safer, lowering our taxes, improving workplace productivity and reducing health care costs.

By "treatment," we mean the broadest sense of the word — a continuum of care that begins with diagnosis and access to appropriate behavioral, pharmacological and spiritual care, and that continues on to support the recovering addict in training for work, completing school, finding housing, and restoring families. To achieve this requires the full support of the community, as well as the coordination of services and resources across governmental and institutional lines. For communities that make this effort, the payoff in improving everyone's life will be well worth the effort.

Policies For Progress

How can our nation get more people on the path to recovery? How can we help Americans understand that treatment is our best hope for reducing substance abuse?

This policy panel was convened to search for those answers. Over the course of a year, we held public hearings, reviewed the literature, consulted with experts, and met to share the wisdom of our collective experience. Out of those deliberations come these recommendations — six policies that our nation must adopt if it is to have greater hope of reducing substance abuse.

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RECOMMENDATION 1

Treatment for alcoholism and other drug addiction must be covered as a health benefit on an equal basis with treatment for other diseases.

It is time for substance abuse treatment to be pulled into the mainstream of health care.

For this to happen, it is essential that health care providers and insurers acknowledge addiction as a chronic, primary, relapsing disease, and treat it as any other such condition, be it hypertension, diabetes or arthritis. Likewise, health care purchasers, in particular employers and governments, must demand that full coverage of treatment be included as a basic element of any health benefit.

Even though addicted persons can go through treatment and achieve at least temporary abstinence, some find it difficult over time to avoid relapse. Many people who achieve sustained remission do so only after a number of cycles of treatment and relapse. Understanding this is key to overcoming the stigma of substance abuse and to making treatment part of the health care mainstream.

Preventing relapse and maintaining recovery requires support from our workplaces, families, schools and religious institutions. For many, these institutional supports have already eroded, and must be initiated or reinvigorated. This means linkages are necessary between these institutions and the treatment site.

Achieving Parity

For substance abuse treatment to be brought up to par with treatment of other chronic diseases, three goals must be met:

- There must be full *coverage* of substance abuse treatment as a basic health care benefit.
- There must be sufficient *capacity* to treat those in need.
- There must be *access* to a variety of substance abuse treatment modalities when and where they are needed.

PARITY LEGISLATION

State Activity

In 1997, 37 states introduced 89 bills that provide equal treatment in health insurance coverage for mental illness and substance abuse. Ten states already have some form of parity laws in place: AR, CO, CT, IN, MD, ME, MN, NH, RI and VT. The Vermont parity law offers the most comprehensive coverage for alcohol and other substance abuse services.

Health Policy Tracking Service, Washington, DC, 202-624-5400, www.ncsl.org/ihpp

Federal Activity

Senator Paul Wellstone (D-MN) and Representative Jim Ramstad (R-MN) introduced a substance abuse parity bill (S. 1147) during the 105th Congress. This bill calls for parity in treating alcohol and other drug dependencies by providing nondiscriminatory coverage for substance abuse treatment services under private group and individual health coverage, and prohibits health plans from imposing discriminatory annual and lifetime caps, copays and deductibles, and day and visit limits on substance abuse services.

National Council on Alcoholism and Drug Dependence press release, Sept. 4, 1997, www.ncadd.org; Health Policy Tracking Service, www.ncsl.org/ihpp; Partnership for Recovery Press Release, Sept. 2, 1997

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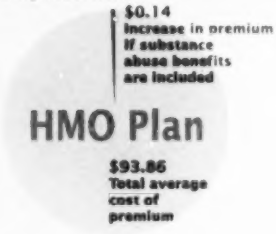
Milliman & Robertson, Inc., examined premium estimates for substance abuse parity provisions for commercial health insurance. The report shows that providing complete substance abuse parity provisions would add minimal amounts to the cost of employers' health plans. M&R estimates that a full parity provision would increase composite premiums by 0.5% or less than $1 per member per month. Full parity would provide equal coverage with other medical conditions for beneficiary cost-sharing provisions (deductibles, copayments, and coinsurance), calendar year inpatient day and outpatient visits, and calendar year dollar and lifetime limits.

Total Average Cost per Month per Member for Full Parity Provision



Employers and insurers may potentially incur savings from the cost offsets resulting from treatment for alcoholism and other drug addictions, thereby reducing medical care utilization and costs. A Rutgers University study found that "on the average, untreated alcoholics incur general health care costs that are at least 100% higher than those of non-alcoholics." After addiction treatment, days lost to illness, sickness claims, and hospitalization rates dropped by about 50%.

Milliman & Robertson, Inc., Premium Estimates For Substance Abuse Parity Provisions For Commercial Health Insurance, Sept. 2, 1997. Langenbucher, J. et al., Socioeconomic Evaluations of Addictions Treatment, Piscataway, NJ: Center of Alcohol Studies, Rutgers Univ., 1994.

A. Parity In Coverage

For those who need treatment, often, the biggest obstacle is cost. For many, lack of health insurance stands as a brick wall between them and treatment services. Even for the insured, coverage sometimes excludes substance-abuse treatment or, at best, provides for only bare-bones services. Unfortunately, the levels and availability of treatment services have in many cases declined over the past decade. The reason for this, in large part, is the growth of managed health care, which has led to cuts in treatment services by:

- setting arbitrary limits on the duration or type of treatment;
- emphasizing short-term savings over long-term outcomes;
- reducing or eliminating treatment services;
- putting insufficient emphasis on quality and individualization of care; and
- using gatekeepers who are poorly trained in substance abuse treatment and have a self interest in keeping costs down.

Purchasers of health insurance, particularly employers and government, may not even be aware of these reductions in substance abuse services, believing that what they contracted for is being delivered. In fact, greater health-care savings are likely to be achieved by expanding substance abuse treatment, not restricting it. Even in the workplace, employers stand to gain far more by expanding treatment services — it reduces absenteeism, lowers training costs and enhances worker productivity.

Thus, the first step towards achieving parity is to include primary care and specialty treatment for substance abuse in all basic health benefits, with appropriate services for family members, including children. This would probably cost insurers and managed-care providers nothing; the direct cost offsets would be at least equal to, or greater than, the cost of adding treatment. By not fully covering treatment, managed-care providers are costing themselves and their subscribers millions.

Employers should not wait for managed-care providers and health insurers to act; they should demand coverage of substance-abuse treatment as a condition of doing business. As employers and major purchasers of health care, it is in their own self interest to do so. Coverage for high quality addiction treatment should be made an express term of agreement between purchasers of health care benefits and managed-care providers.

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For poor and elderly people, Medicaid and Medicare should likewise provide for substance abuse treatment at least on par with other chronic diseases. State contracts with managed-care providers should require this. State governments should set aside funding to provide treatment for the uninsured. Some revenue for this could come from taxes on alcohol and nicotine. Steps must be taken to ensure that people who rely on the public health care system have access to treatment.

As state governments implement policies to move welfare recipients into the workforce, they must also devise programs to address this population's health needs, particularly as they relate to substance abuse, and to provide related housing and child-care services. Effective implementation of the nation's welfare-to-work reform will be placed in jeopardy if appropriate treatment is not coordinated with this initiative.

The Legal Action Center, in its 1997 report, "Making Welfare Reform Work," estimates that 15-20 percent of welfare recipients are dependent on alcohol or other drugs, compared to nearly nine percent of non-recipients.[10] Most states need to take further steps to successfully implement welfare reform. For instance, the states which are implementing welfare reform need additional preparation. This report showed that only five states had estimates of the number of welfare recipients with alcohol and drug problems, and fewer than one-third had plans to increase state funding for alcohol and drug treatment targeted at welfare recipients. Fortunately, the new law does provide states with opportunities for identifying welfare recipients with alcohol and drug problems, and bringing to bear needed resources to provide them and their children with treatment and prevention services. [See p.35, Cleveland CARES welfare-to-work transition program.]

A second step in achieving parity of coverage is to expand the scope of covered treatment to include the full continuum of services necessary to achieve appropriate outcomes and sustain recovery. This extends from inpatient detoxification and counseling to outpatient treatment and relapse prevention, and includes health and mental health services, educational and vocational programs, family treatment and support services. Treatment decisions, therefore, must be made using objective guidelines derived from research and clinical practice, and treatment must be sufficiently flexible to match the needs of the individual and the severity of the illness. Coverage must also provide for simultaneous treatment of substance abuse disorders and their physical and psychiatric comorbidities.

For managed-care providers, this means abandoning generic approaches to treatment in favor of more individualized therapies. Research indicates that the longer an individual remains in treatment, the better the results. The

course, length, intensity and type of treatment in any given case should be determined based on individual diagnosis and clinical necessity, by using objective guidelines. Any limits on treatment days, visits or payments should be made based on appropriate principles as with other chronic diseases. For example, some patients need inpatient care for part of their recovery. These individuals shouldn't be required to "fail" in other treatment settings first before being placed in the most appropriate level of care.

B. Parity in Capacity

To make addiction treatment the equal of treatments for other chronic diseases, capacity must also be enhanced. This expansion must meet the needs of both the private and public systems.

At the panel's public hearing in Chicago, witnesses from both the private and public treatment systems testified to the limited access to available treatment slots. In Illinois alone, in 1996, there were an estimated 764,000 people in need of treatment, but the state could accommodate only 116,000. At any one time in Illinois, there is an active list of 1,500 individuals waiting for treatment. No one knows how many others gave up or never even tried.

This lack of capacity for substance abuse treatment exists in stark contrast to the medical system's capacity to treat other diseases. If a person fell this morning and needed a hip replaced, it could be done this afternoon. But if this same person suffered relapse of an addiction, s/he might have to wait four weeks before getting help.

Expanding coverage of substance abuse treatment would go a long way toward expanding capacity. Just as supply rises to meet demand, more money for treatment services would result in wider availability of services. But waiting for the market to respond to the demand would take time, and even then would require new staff, more training and the construction of new facilities.

C. Parity In Access

The third greatest obstacle to getting treatment for those who need it is access. High cost and limited capacity, of course, are themselves barriers to access, but other barriers exist as well. Among them:

- A lack of timely treatment. When a client presents for detoxification, immediate services should be available. This requires the elimination of waiting lists and delays in authorizing treatment.

- A lack of geographic proximity. This is an obvious problem in many rural communities, but even in cities, whole neighborhoods may be without any treatment services, may lack services that match the need, or may be unable to reach treatment due to inadequate public transportation.
- A lack of linguistic, cultural, ethnic or gender competence.

Treatment must be made linguistically, culturally, geographically and psychologically accessible. This means that every community should have access to a full range of treatment services. This does not mean that all services must be provided within the community; only that those in the community have somewhere nearby to turn to that meets their needs. Emergency treatment and detoxification services should be available around the clock for all citizens, regardless of ability to pay. Treatment staff must be trained to make their services easy to use and understand. They must be trained about issues of culture, ethnicity and gender, and they must be prepared to provide treatment in the client's dominant language.

A significant factor in ensuring access to substance abuse treatment is its integration into the health and mental health care systems. Screening for, assessing and intervening in substance abuse should be part of general medical and mental health practice. Most importantly, substance abuse must be recognized as a primary disease and all primary-care physicians, nurses, psychologists and social workers must be trained to identify substance abuse — and the children of substance abusers — and to order appropriate referral. We must reach a point in our perception of this disease where health and mental health care providers understand that failure to diagnose it under some circumstances would be considered malpractice.

Once again, the business sector is ideally situated to demand substance abuse screening from its health providers. Treatment of addiction at any stage is economical for employers, but the earlier it is diagnosed, the more likely treatment is to be successful.

" I thought this would only happen to people who didn't work or take care of their children."

A 74-year-old grandfather on how addiction has torn apart his family; he now raises his 4- and 5-year-old grandsons while his son is in jail and on work release for drug-related offenses.

Limited access to treatment for alcoholism and drug addiction is a national crisis that calls for a broad-based, national campaign to educate the public and build political support.

It is time for those at the forefront of the health-care system to stand up and declare substance abuse to be the national, public-health crisis that it is, and to take the lead in building a broad-based, national campaign to overcome the stigma of substance abuse.

Professional health organizations, and, in particular, the American Medical Association, should take the lead in helping policy makers and the American public understand that alcoholism and drug addiction are not crimes, but diseases with biological, psychological and sociological components. They should educate this nation about the nature of addiction and about treatment and its successes.

These organizations can play a critical role in helping the public to understand that treatment of individuals is prevention for families and communities; that treatment is the most effective and economical way to reduce drug and alcohol use, related crime and other social ills. Such understanding will lead to greater public support and demand for expanded treatment services.

Why such a campaign? Because the message is not getting out and is not yet widely understood. Those who have been trained to work with people who have substance abuse problems, whether as a physician, therapist, treatment provider, judge or cop on the street, know that expanding treatment is our best hope to reduce substance abuse in America. But the public has failed to grasp this and many legislators ignore the facts in favor of more dramatic, albeit misguided, lock 'em up policies.

Nearly 100 mayors, police chiefs and prosecutors from across the nation met in Washington, DC, in May of 1997, to discuss the key components of effective anti-drug efforts and to finalize a national action plan. Mayors Scott King of Gary, IN, and Brent Coles of Boise, ID, are the co-chairs of this Mayors' Task Force on Drug Control. Among the Task Force's key points: reaching America's young people and convincing them not to use drugs must be the first priority; drug abuse will not be reduced in this country without adequate treatment resources; and increased prevention and treatment must be accompanied by strong enforcement measures. The plan was presented to the President, members of his cabinet and Congressional leaders.

U.S. Conference of Mayors, Washington, DC, 202-293-7330, www.usmayors.org

The Federation of American Scientists, a group of researchers who are engaged in analysis and advocacy of science, technology and public policy, convened 35 of its members to redirect the discussion and action around drug abuse control. This group, the Drug Policy Project, issued the following statement regarding treatment:

- **Treatment must be valued properly. Successful treatment for people with substance abuse disorders produces benefits for those treated and for those around them.**
- **Treatment episodes that reduce drug use and damage to self and others but do not produce immediate, complete, and lasting abstinence ought to be regarded as incomplete successes rather than as unredeemed failures.**

Federation of American Scientists, Washington, DC, Phone: 202-546-3300, www.fas.org

The medical establishment in particular would be an effective force in creating a vocal constituency for alcoholism and drug addiction treatment, acting as new standard bearers to build a political base and community coalitions that would lobby for a public health approach to reducing substance abuse.

A major step in this direction occurred recently when a group of prominent physicians, the Physician Leadership on National Drug Policy, declared that the nation's drug policy is flawed and should be redirected to a public health approach that treats addiction as a chronic disease [see Appendix II, p.33]. Chaired by Dr. June Osborn, professor of epidemiology and former dean of the University of Michigan School of Public Health, the 37-member group includes a past president of the AMA, medical educators, leading medical editors, and former Reagan and Bush administration health officials.

Now others in the medical, mental health, public health and professional communities must follow suit, with the aim of building an effective movement to advocate in favor of treatment and against ineffective and wasteful strategies for reducing substance abuse.

"Not long ago, I was facing the prospect of two years in jail due to my drug related problems. Instead, I entered an inpatient treatment program, which at first I fought with all my heart and soul. I did not want to be exposed for the evil person I felt I was. In treatment, I found self-acceptance. I learned that if I really wanted what the recovery program had to offer and worked the program, I would achieve success. Even in spite of life's difficulties, success is all I've known since treatment. I am working on my 12th year of sobriety. It is great to be free from the dominance of drug dependency."

Jesse, Age 49, Director, Substance Abuse Agency

Join Together produces a variety of print publications, including Monthly Action Kits, which help make the link between substance abuse and other social problems.

One such kit focuses on national public awareness campaigns for 1998 and comes with a colorful companion calendar designed to remind you of these events throughout the year.

For more information about Join Together or to request a free single copy of this kit, you can write to Join Together at 441 Stuart St., 7th Floor, Boston, MA 02116, call (617) 437-1500, fax a note to (617) 437-9394 or send an e:mail to info@jointogether.org

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Recommendation 3

Research on the nature and treatment of substance abuse and recovery should be expanded. The results should be made more promptly and easily accessible to professionals, policy makers and the public.

Although much research has been conducted on substance abuse treatment and its effectiveness, more research is needed commensurate with that conducted for other chronic diseases for purposes of both medical inquiry and public education. Also needed are means to more broadly and effectively communicate the results of research to professionals and the general public and, in particular, to make research rapidly available to practitioners.

A key role that research has played and must continue to play is in helping to demystify and destigmatize substance abuse in the eyes of the general public. Too many people do not understand the disease of addiction, and that is a fundamental reason why addicted people and alcoholics have such a difficult time getting help. Research can help make people understand the power of addiction, the costs to society and the possibilities of recovery.

At the same time, it is vitally important that we continue research on treatment efficacy and cost-effectiveness as well as on related pharmacological issues, particularly cocaine pharmacology. Likewise, there must be ongoing studies in the fields of treatment methods, case management, cost benefits and outcomes.

There is a great need for expanded research in communities. In part, this should take the form of research and demonstration projects aimed at new or innovative community treatment services. But there is also a need for a broader kind of community research, helping communities develop localized, multifaceted responses to substance abuse, of which treatment would be one part. The Institute of Medicine Committee on Community-Based Drug Treatment is offering recommendations to bridge the gap between research and treatment.[1]

To bridge the gap between research and the community, the National Institute on Drug Abuse (NIDA), has held several Town Meetings on Understanding Drug Abuse and Addiction. These meetings are designed as a dialogue between scientists and citizens to educate the public about drug abuse problems in their states and cities, and to discuss how to shape local and state policy.

Town meetings have been held in: Miami, St. Louis, Columbus, Tampa, San Francisco, Dallas, Philadelphia, and Chicago.

National Institute on Drug Abuse
Rockville, MD, 301 443 6245
www.nida.nih.gov

All of this research will be of little practical effect unless the research community and treatment providers work together to create a uniform system for collection and delivery of data. Specifically:

- Data must be collected using standardized methods, diagnostic criteria and nomenclature, so that there can be accurate tracking and measuring of clinical and administrative performance.
- Data, once collected, must be made easily and rapidly accessible to treatment providers, clinicians, policy makers, opinion makers, purchasers and the public.
- Research institutions, government agencies and treatment providers must form partnerships to ensure ongoing dialogue with each other and with policy makers and communities in need of treatment services.

Finally, we must close the gap between research and practice. Data collected through research must be put to use in a timely fashion to ensure that all providers are delivering treatment that is effective and efficient. Ultimately, research serves the common good by ensuring quality of treatment services and accountability of providers.

The National Council on Alcoholism and Drug Dependence convened a Committee on Treatment Benefits (COB), which is devising a strategy to objectively measure which treatment services are most cost efficient and clinically effective. COB is developing software applications for use by treatment providers and payors to measure treatment outcomes. This computer application will allow providers to collect outcome data and may revise the treatment financing process.

NCADD Amethyst Newsletter, Winter 1996, Vol. 4, No. 4, National Council on Alcoholism and Drug Dependence, NY, NY, 212-206-6770, www.ncadd.org.

" The shambles of my alcoholic life led me to an AA program. In this safe environment, I learned how to live clean and sober. I returned back to college to complete my degree, earned an M.A., and continue to work in a successful media career. It's been 23 years now and I am grateful every day."

Susan, Age 46, Newspaper Columnist

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RECOMMENDATION 4

Education and training on the nature of addiction and recovery should be required for all health, mental health, social service and justice system professionals.

"All practitioners should possess the skills necessary to recognize the risk factors and signs of substance abuse in their patients (including a family history of alcoholism), and should be able to evaluate the nature and extent of alcohol use and to offer appropriate counseling or referral."

Hoover Adger, Jr., MD, MPH, former Program Vice President, National Association of Children of Alcoholics, Rockville, MD. 301-468-0985 www.health.org/nacoa

Primary care physicians see more alcohol and drug abusers accidentally than treatment professionals do intentionally, one provider testified before this panel.

It is estimated that two out of every three substance abusers will see a primary or urgent care physician within the next six months. Will that physician be prepared to recognize the patient's problem and respond appropriately?

Too often, the answer is no. Medical schools do not sufficiently prepare students to diagnose and respond to alcohol and drug problems and to address the needs of the children and adolescents living in families affected by it. Nor do nursing schools. Nor do schools of psychology or social work.

Project ASSERT (Alcohol and Substance Abuse Services and Education for Referral to Treatment) is an innovative program based at the Boston University School of Medicine. This program uses health promotion advocates (HPAs) to identify patients in the emergency room who may have substance abuse problems. If a patient gives consent, the HPAs refer these individuals to treatment and prevention programs, and other primary care services. Follow-up services are also conducted to monitor patients' improvement upon release from the hospital. This project has shown positive results including reduced drug use among patients and reduced emergency department costs and utilization.

Edward Bernstein, M.D., Boston Medical Center, Boston, MA. Phone: 617.534.4929

Primary care doctors, nurses, psychologists and social workers are on the front lines of the health care system. They are uniquely positioned to recognize, diagnose and intervene in cases of substance abuse — often at a much earlier stage than other health care providers. If we are ever fully to integrate substance abuse treatment into that system, they must know how to intervene and refer.

At a minimum, primary-care professionals should, as a matter of course:

- routinely screen for the presence of alcohol or drug problems and risk factors by asking a few key questions;

- assess the nature and extent of alcohol, nicotine and drug use by patients;
- intervene appropriately;
- be aware of treatment resources and arrange referral relationships for addicted patients and family members, including the 11 million children of substance abusers under the age of 18; and
- provide ongoing, general medical care to those with alcohol or drug problems.

In order for this to happen, every relevant health, mental health and public health professional must be schooled in addictive disorders and invested with treatment knowledge and expertise. All health professionals should receive training on addiction and treatment as part of their education. License examinations, board examinations, accreditation standards and continuing education curricula should include relevant questions and criteria.

"We (the members of the Macy Foundation Conference on Training Primary Care Physicians on Substance Abuse) recommend that the primary care specialties should require all residents to acquire those competencies necessary to prevent, screen for, and diagnose substance abuse problems; to provide initial intervention for these problems; to refer patients for additional care when necessary; and to deliver follow-up care." David Lewis, MD, Josiah Macy, Jr. Foundation conference chair.

Macy Foundation Conference Proceedings, 1995. Contact David C. Lewis, M.D., Dir., Center for Alcohol and Addiction Studies, Brown University. Phone: 401-444-1818.

While education of primary health and mental health care providers is of utmost importance, it is equally important that any professional who is likely to encounter substance abuse as a matter of course be trained to recognize it and respond appropriately. This includes those in the justice system, schools, community services, business, government, and the faith community. It ranges from the cop on the beat to the teacher in the classroom to the company human resources officer.

" I've been doing drugs since I was 12. I didn't understand that I have a disease. I am sick, but my whole family gets affected. . . Thank God I took the suggestion to get treatment for me and my family. I'm 37 years old and I'm now learning how to be a man."

A 37-year-old substance abuser talking about his drug use and his involvement with a community-based program.

The Addiction Technology Transfer Centers (ATTCs) were formed to address the shortage of well-trained addiction treatment professionals and the number of health professionals providing treatment services. To achieve this federal mandate, the program is designed to increase the number of health and allied health care practitioners in nonprofit substance abuse treatment and recovery programs. Two goals include linking publicly-funded addiction treatment and recovery programs with institutions that train health and allied health care practitioners in order to improve the practitioners' competencies, and to strengthen addiction treatment curricula within institutions and programs that train practitioners.

Addiction Technology Transfer Centers, Center for Substance Abuse Treatment, Rockville, MD, 301-443-8521, http://views.vcu.edu/nattc/

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RECOMMENDATION 5

Treatment for alcoholism and drug addiction must be monitored by independent treatment managers with no vested financial interests in order to ensure ongoing treatment effectiveness.

The Minnesota Consolidated Chemical Dependency Treatment Fund, which began in 1988, pays for drug and alcohol treatment for Minnesotans who need it but cannot afford it. The Fund pools money from various state and federal funding streams to create a seamless system of care. Eligibility for the Fund is based on income and is determined by trained professionals who utilize a standardized, independent assessment process which directs clients to clinically-appropriate services. It is estimated that approximately $7 million was saved in 1992.

For guidelines on contracting with managed care organizations for substance abuse treatment, contact Cynthia Turnure, Ph.D., Director of the Chemical Dependency Program Division at the MN Department of Human Services.

The MN Dept of Human Services, Chemical Dependency Division, St. Paul, MN; 612 296 4767

A significant failing of managed health care is that it must constantly seek the middle ground between two conflicting interests. On one hand is the interest in providing complete, quality health care. On the other is the interest in keeping health-care costs to a minimum. Managed care's search for a middle ground has often meant cutting corners. Perhaps nowhere has this been felt more deeply than in the area of substance abuse treatment. Long on the periphery of the health care system, substance abuse treatment has been easy prey for managed-care's cost cutters.

The relationship between managed care and substance abuse treatment is further strained by managed care's reliance on "medical necessity" as a standard for deciding whether and what sort of treatment is appropriate. Substance abuse treatment encompasses a wide-range of services, from diagnosis to aftercare, and its various modes often do not fit squarely into a medical necessity model.

One way to balance these inherent conflicts is to put all assessment and placement decisions in the hands of independent case managers. These must be individuals who are experienced in the field of alcoholism and drug abuse treatment and who have no personal or professional conflicts of interest, whose only purpose is to ensure the quality and appropriateness of treatment. The federal and state governments should mandate the use of independent treatment managers, and employers and other health care purchasers should likewise demand their use. Such mandates should ensure that practitioners and providers do not review their own programs or programs in which they have administrative oversight, and that there be a separation of treatment managers from funding decision-makers.

RECOMMENDATION 6

Diagnosis, treatment and long-term recovery must be integrated into a coordinated, community-wide strategy to reduce alcohol and other drug problems. This strategy should encompass economic development, health and mental health care, the justice system and other key institutions.

People with drug and alcohol problems are our friends, family members and co-workers. They live in our neighborhoods and attend our places of worship. They carry with them a wide range of related social, legal, economic and medical problems. Indeed, those with the most severe problems often have the weakest social supports necessary to maintain recovery and prevent relapse.

For this reason, treatment of alcoholism and drug addiction is a process that must involve the family and community as well as the individual. Treatment, at least in the clinical sense, may begin in a health facility, but eventually it extends to the community, as the recovering person begins to rebuild a life — looking for work, finding new supportive relationships, seeking out housing, locating child care. Even before conventional treatment begins, the community plays a role, through its police, its courts, its schools, and its social service agencies, helping to identify substance abusers and direct them to help. Family members, as well, play a critical role, both in providing support for the recovering person and in having their own needs for attention, support and social services.

We must broaden the definition of treatment and recovery to include everything from a police officer's intervention in a drug-related crime to an employment counselor's work with a recovering alcoholic. We must broaden the definition of treatment to recognize that the community and its institutions play a vital role in an addicted person's recovery – and ultimately in our overall success at reducing substance abuse in our community. When we understand that addiction is a disease, and, in particular, a disease whose sufferers are prone to relapse, we better understand the important role that is played by the family, the workplace, the community and its institutions in a person's recovery from addiction.

Broadening our understanding of treatment and recovery also reinforces the value of coordination — coordination among all actors and services in the community with a role to play in encouraging or providing substance abuse treatment. If treatment is to be successful, then communities and the institutions within them are essential participants in the treatment process.

La Bodega is a model program based on the premise that healthy families can actually help addicts succeed in drug treatment and stay out of jail. This program operates on the lower east side of New York City and works with more than 30 families who live in a densely-populated, low-income area, providing them with 24-hour crisis intervention, case management, walk-in counseling, relapse prevention, referrals to drug treatment and health clinics and advocacy in court.

Carol Shapiro, Project Dir., La Bodega de la Familia, NY, NY, 212-982-2335, E-mail: cshapiro@vera.org

The workplace has been shown to be an effective place for intervening with people with substance abuse problems. Union participation improves this process by spotting problems before they become serious. For example, the Central Labor Rehabilitation Council (CLRC) in New York City refers several hundred people a year for help for substance abuse problems. "People come to us because we have a good track record on return-to-work," said Jack Gehan, CLRC's executive director. During a one-year period, CLRC found that 85% of the people who sought assistance for substance abuse problems had lost their jobs or were about to lose them. Of this group, after receiving referral and counseling, 92% were working.

Central Labor Rehabilitation Council of New York, NY, NY, 212-532-7575

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A. The Justice System

We cannot emphasize strongly enough the key role played by the justice system — both civil and criminal — in broadening the reach of treatment. Substance abusers are likely, for one reason or another, to find their way into the justice system. When they do, judges and other justice officials are uniquely situated to encourage — and in some cases even require — treatment. Many who abuse alcohol or drugs get arrested for crimes ranging from driving under the influence or possession of controlled substances to breaking and entering, assault and battery, larceny or firearms violations. Others come in through the civil side of the courthouse. Their marriages are ending or their children are being taken away from them. They may be getting evicted from their homes. Possibly they have been involved in domestic violence or in visitation or custody disputes.

"There is no other circumstance in our society where there exists such a high intersection between the presence of substance abuse and the power and leverage of an institution than presently exists when the substance abuser and the courts intersect," reports a 1995 Massachusetts task force on substance abuse and the courts.[1]

The Flaschner Judicial Institute has developed an "All Court Conference on Alcoholism and Substance Abuse" for the Supreme Judicial Court of Massachusetts. The conference, to be held in 1998, will aim to improve the judiciary's response to substance abuse. This will be the first time a state court system will close its courts to focus its entire judiciary's attention on the emerging responsibility of judges to address alcoholism and substance abuse directly. The All Court Conference will inform the state's judges of their evolving responsibilities in this area, and apprise them of new standards for how courts are to deal with alcoholism and substance abuse.

Thus, for communities, the justice system is a critical place to begin the integration of substance-abuse treatment and its coordination across institutional lines. All those who play roles in the system, from police officers to judges, from family counselors to probation officers, should be prepared to identify and respond appropriately to substance abuse, and access to treatment must be made an integral part of the system. In particular, this means:

- Treatment must be available — and, where appropriate, required — for every addicted person who comes in contact with the justice system, at every step of the justice process and must be provided in a coordinated and continuous manner.

- Judges, police officers, probation officers and others who work in the justice system should attempt to identify and appropriately respond to the indication of substance abuse among those who come into the system.
- Courts should provide diversionary treatment programs and allow for deferral of prosecution or sentencing during treatment.
- Courts should not be exclusively criminal or civil, but should have authority over all aspects of a substance abuser's legal problems, be they criminal, domestic, housing-related or otherwise.
- Criminal justice agencies must work as equal partners with, and gain greater access to, prevention and treatment programs and related educational and job-skills programs.
- Justice professionals at every level of the system should receive training in the nature of substance abuse and its recovery, including the full range of treatment proven to be effective. Although specialized responses such as drug courts are commendable, every court should have available drug court sanctions, and every judge should have the sentencing prerogatives of a drug court judge.

It is important to note that treatment, particularly for those within the criminal justice system, must encompass a wide range of services. Many of the people who are arrested or incarcerated come from disadvantaged backgrounds, lacking social and vocational skills. For them, an otherwise successful treatment program might result in failure because they cannot read, have no employment experience and cannot find work. To be truly successful, therefore, treatment must encompass a continuum of therapeutic, social and vocational services.

A note of caution: even as communities work to integrate treatment within the criminal justice system, they must be careful that this strategy does not backfire. Treatment can serve as an anti-crime measure when readily available and accessible. For this to happen, communities must assume responsibility to provide adequate voluntary treatment, so people can avoid engagement with the criminal justice system.

Over-emphasis on drug courts and prison treatment programs can result in treatment funds being carved out or diverted disproportionately into the criminal justice system, with the ironic result that some people needing treatment, especially among the poor, have nowhere else to turn. Communities, in other words, should not require someone to throw a brick through a window in order to get treatment.

Finally, providing treatment is not pandering to offenders, it is promoting safety in our communities. Law enforcement must continue to be our immediate response to drug-related crime and violence. But merely arresting and incarcerating substance abusers, without more, does little over time to make our streets safer. Locking up addicted persons or juvenile offenders from families devastated by substance abuse without also treating them does nothing to cure their addiction, and as long as there are addicts, there will be drugs to supply them — even, if necessary, in jail. The only meaningful, *long-term* answer to drug-related crime is to reduce demand through treatment and prevention. Treatment and rehabilitation should be in addition to, not in place of, other consequences. Treatment is no less difficult than punishment. While many addicts might prefer simple incarceration to the more rigorous demands of treatment, only treatment will guarantee that our communities will be safer in the long run.

Insure the Children is a city-administered program designed to provide outpatient substance abuse services to children between the ages of 7-18 who reside in Little Rock, AR. This program is funded by a half-cent sales tax which provides over $1 million annually. Coordinated through the Arkansas Children's Hospital, three levels of outpatient services are offered. Most referrals originate from local schools, although health care and community organizations can direct young people to the program. Recent evaluation indicates high parent and child satisfaction with the program, and reduced substance abuse among those who have completed the program.

Rick Colclasure, Dir., Community Programs, Little Rock Fighting Back, Little Rock, AR. 501-399-3420.

B. Throughout The Community

Beyond the justice system, communities must strive to integrate treatment services and resources across all sectors. Integration would include:

- Coordinating services such as job placement, skills training, housing assistance, transportation and day care while in treatment and afterward.
- Converting abandoned or outdated community properties into long-term residential care facilities.
- Maintaining a community-wide referral system for treatment services, including social and medical services.
- Encouraging cooperation among community institutions, including health-care providers, law-enforcement officials, educators, clergy and businesses.

Communities may find it beneficial to designate one entity to coordinate treatment, aftercare and related substance-abuse services. In Chicago, for example, the Mayor's Office of Substance Abuse Policy addresses everything from zoning of treatment programs to federal and state welfare reform. It works with local advisory councils and community police to monitor the needs and problems of each neighborhood. It even acts as a referral service and advocate, helping residents who need treatment to find it.

All of this means that health care professionals should cooperate with criminal justice professionals. Judges and private treatment facilities should coordinate referrals. Local leaders should help formulate state and federal policies affecting treatment services. Faith leaders, school officials and youth workers, employers and labor officials must play key roles. Neighboring towns should coordinate and share scarce residential and aftercare services.

Integration must be encouraged not only within a defined community, but also among and across communities. No community exists as an isolated entity. A "community" might be an urban neighborhood, a unit of government, a grouping of professionals, a particular industry, or even an entire nation. What is critical with regard to treatment is that, whenever possible, there be sharing of resources and common planning and policy across community lines.
Every community is touched and hurt by substance abuse. Making substance abuse treatment more available would be a giant step toward advancing the common good.

Treatment: Our Best Hope

Addiction does not discriminate. It spreads through our nation without regard to location, class, race, religion or gender. It leaves a path of personal, family and community suffering.

We have allowed this problem to thrive by refusing to recognize it for what it is. We have called it a crime problem, a character flaw, a social aberration. We have called it everything but what it is, a serious and chronic disease, no different than cancer or heart disease. It is a disease that has reached widespread proportions, a public health problem that has overwhelmed our nation.

Because we have persisted in mislabeling it, our policies have failed to thwart its growth. We have spent billions of tax dollars on locking up drug users and cutting off their supplies. In pursuit of public safety, we have built more prisons, lengthened sentences and talked tough — with little impact.

Our best hope for reducing the suffering from addiction is to acknowledge addiction as a biopsychosocial disease and treat it as such. In particular, our health care system must evolve to the point where it looks equally on the alcoholic and the diabetic, the addict and the cancer patient.

Getting to that point will require a fundamental shift in policy and point of view. But the process will be hastened if public leaders stand up and speak out for substance abuse treatment. National medical organizations should be at the forefront of protecting our nation's health. Their lead would provide the momentum to propel a national campaign for substance abuse treatment.

Only when health insurers, managed care providers and policy makers accept substance abuse as a disease on par with any other will we begin to make meaningful progress in reducing substance abuse. Only then will our streets be safer, our workplaces more productive, our families more stable and our communities more cohesive.

As a young child living on a Navajo reservation, Helen Waukazoo learned about the effects of alcoholism and drug addiction. In an effort to reduce this problem, Waukazoo helped found the Friendship House Association of American Indians, Inc. Under Waukazoo's direction, what began as a tiny program has grown into the only co-educational, state licensed, nationally accredited substance abuse facility treating American Indians in California. This program provides culturally-sensitive residential substance abuse treatment services to American Indians with addictions. "For me, the founding of Friendship House was the beginning of hope for American Indians who are afflicted with the disease of addiction, as we learned to provide healing and renewal for our people and our community," she explains.

Helen Waukazoo, Ex. Dir.,
The Friendship House Association of American Indians, Inc.,
San Francisco, CA,
415-431-6323.

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Background
— The Efficacy of Treatment

Abundant research documents that appropriate treatment:

- is the most effective way to reduce drug and alcohol addiction; and
- dramatically reduces drug and alcohol related crime and health-care costs for both purchasers and providers, as well as other social costs.

Consider these facts regarding the efficacy of treatment.

Treatment Reduces Substance Abuse

Treatment is not an antidote; it cannot be administered once with the expectation that the addicted person will recover for life. As almost everyone who has ever smoked cigarettes more than a few times knows, overcoming addiction is often a process of trying and failing and trying again. Even when abstinence is achieved, desire often remains.

No one expects people with diabetes, asthma or hypertension to go for treatment once and come home cured. We understand that chronic diseases require long-term management and periodic professional services. It is similar with alcohol and drug abuse. Substance abuse is a long-term condition that requires a long-term course of varying degrees and modes of care. Just as a diabetic may occasionally relapse into shock, the substance abuser may occasionally relapse into abuse. Just as diabetics must be taught new habits of diet and exercise, substance abusers must be helped to re-establish healthy work and family lives. Thus, for either disease, the success of treatment is measured in terms of functional improvements: Did the treatment result in better health, a return to work, a happier family, a safer community? The measure of treatment's success requires factoring in not just the individual, but also the family, the community and the workplace.

That said, there is nevertheless compelling evidence of treatment's effectiveness in reducing substance abuse. Dr. David Lewis, director of the Center for Alcoholism and Addiction Studies at Brown University, told this policy panel, "Our outcomes are at least as positive as other chronic illnesses, if not better, yet substance abuse continues to be held to a higher standard of outcomes and cost-effectiveness." For example:

- Providing treatment to all addicts in the U.S. would save more than $150 billion in social costs over the next 15 years, a 1996 study found.[xv]
- Treatment reduced heroin and cocaine use by more than half one year after treatment, and cut drug expenditures by almost 70 percent, the National Treatment Improvement Evaluation Study (NTIES) found.[xvi]
- Treatment reduced the percentage of individuals who visited medical centers for alcohol or drug related reasons from 24.7 percent to 11.5 percent, according to NTIES.
- Outreach services for injection drug users led more than half to reduce or stop their drug use, according to 1995 data from 33 treatment agencies nationwide. Adding treatment services to outreach led to even greater improvement, with 86 percent reducing or stopping their drug use.[xvii]
- A Los Angeles program found that increasing the number of individual and group counseling sessions cut participants' drug use to 40 percent lower than that of other clients.[xviii]

Treatment Reduces Crime and Its Costs

As much as 80-90 percent of all crime in the U.S. is committed by persons under the influence of drugs or alcohol.[xix] The best and cheapest way to cut this crime, studies show, is to treat the underlying substance abuse.

A May 1997 report released by the RAND Corporation determined that treatment is far more effective in reducing cocaine use and related crime than either mandatory-minimum prison sentences or conventional law enforcement.[xx] For every $1 million spent, the study found, treatment would reduce cocaine use by more than 100 kilograms, compared to a reduction of 13 kilograms from mandatory-minimum sentences and 27 kilograms from conventional law enforcement. In reducing crime, the study concluded that treatment is 15-17 times more effective, meaning that for every one crime that incarceration would eliminate, treatment would eliminate at least 15.

An earlier RAND study found that treatment of drug users was far more effective in reducing drug-related crime than were government efforts to seize illicit drugs.[xxi] Other studies reported similar findings:

- California found that illegal activity dropped 43.3 percent after providing treatment. The longer the participants remained in treatment, the greater the drop.[xxii]
- Illinois found that offenders who received treatment while in jail and aftercare following release committed significantly less crime than other offenders.[xxiii]

- In Maine, a survey of offenders who had gone through treatment found that, after a year, 79 percent had no further arrests.[xi]

Not only is treatment the most effective way to reduce drug-related crime, it is also the cheapest. Consider these facts:

Every dollar spent on treatment leads to a $7.46 reduction in crime-related spending and lost productivity, according to a study conducted by RAND for the Office of National Drug Control Policy.[xii] A California study similarly found that every dollar spent on treatment saved taxpayers $7.[xiii] Treatment is far cheaper than interdiction, enforcement and prosecution. RAND estimates that a one percent reduction in annual drug consumption over the next 15 years would require spending $783 million for source-country control, $366 million for interdiction, $246 million for domestic enforcement, or $34 million for treatment.[xiv]

When Kaiser Permanente contracted with the state of California to provide health coverage for Medicaid recipients, it decided, although not part of the contract, to provide two communities with a full range of chemical dependency services, from detoxification to aftercare and family counseling. By adding this extra benefit, Kaiser found it actually reduced this population's overall health costs. Significantly, after just a year, substance abuse treatment resulted in a 50 percent reduction in hospital days for other illnesses among treated patients. Kaiser found similar results among its commercial patients.

Steve Allen, Ph.D., Program Director, Chemical Dependency Services, Kaiser Permanente Medical Center, Vallejo, CA, 707-648-6000

Treatment is far cheaper than incarceration. Incarcerating an adult for one year costs up to $37,000. In contrast, residential substance-abuse treatment costs an average of $14,600 and outpatient treatment costs an average of $2,300.[xv]

Treatment Cuts Health Care Costs

While there is a cost for treating drug and alcohol addiction, the cost for treating related health and psychiatric conditions is far greater. The health cost of addiction, excluding nicotine, has been estimated at $140 billion a year. Alcoholism, alone, is associated with 25 percent of all general hospital admissions. It follows that if you reduce substance abuse, you reduce hospitalizations and related health-care expenditures.

The recent experience of Kaiser Permanente Medical Center in Vallejo, California, validates this premise. When this health maintenance organization added a full range of addiction treatment services for Medicaid recipients, it found it actually reduced this population's overall health costs. Based on Kaiser's experience, the County extended these services to all of its Medicaid members.[xvi] (See sidebar.)

The lesson learned by Kaiser is simple: Not only did treatment improve the lives of its patients, their families and their communities, it also saved money. Other studies tell similar stories:

- A California-based study suggested that more than $7 is saved in medical and social costs from each dollar spent on drug treatment.[vii]
- The California Drug and Alcohol Assessment Study estimated savings of more than $1.5 billion in health care costs and crime reduction from treating 150,000 addicts at a much reduced cost of $209 million.[viii]
- A Blue Cross/Blue Shield study found that treatment resulted in a collateral drop in the health care costs of family members by more than 50 percent.
- A study of employees who underwent substance abuse treatment found abstinence rates of more than 60 percent after one year.

The panel heard words of caution with respect to policies that "carve out" publicly funded substance abuse or behavioral health services from mainstream health care. With an eye toward increasing potential savings, a range of options are underway in several states, generally establishing a separate managed care entity or system to provide addiction treatment. A review of the Massachusetts Medicaid program suggests that where addiction is carved out, substantial savings are achieved primarily through reduction in the use of acute care hospitals and increasing the use of detoxification centers. Quality of care appeared to remain consistent with that offered before the managed care carve out.[ix]

Witnesses at the panel's hearing warned, however, that financial savings through the carve out may be diminished or nonexistent in the short term if effective strategies exist for assuring access for addicted patients to the mainstream care program. This may cause a financial disincentive for providing access to the full service health care system. Consequently, measures for these carve out programs need to look beyond immediate savings, and states will have to focus on effective treatment and recovery outcomes. States will also need to establish standards for appropriate levels, as well as duration of care, to ensure long term treatment efficacy as well as cost effectiveness across the entire health care spectrum.

Overcoming The Stigma

Given these facts, why do adolescents and adults who are addicted to alcohol and other drugs often not receive proper treatment? Certainly, if a treatment existed that would substantially reduce cancer, we would make it available to anyone who needed it. If we could reduce heart disease at a faster rate, we would do so. Why is substance abuse different?

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Part of the answer is economic. Many of the people addicted to alcohol and other drugs in our country who go untreated are also among our nation's poorest; they cannot afford to pay for treatment and they have inadequate insurance — or none — to cover its costs.

Even among the insured, substance abuse treatment is increasingly unavailable. Managed care plays a major role in this regard, cutting treatment benefits even in the face of strong evidence such as the Kaiser Permanente experience.

Hovering over all of this is the stigma of substance abuse. Addicted people are judged to be bad, weak-willed, often criminal. Many people either do not understand, or reject, the biological basis of the addiction. We take what is at essence a health problem and write it off as moral failure. We rely on the criminal justice system for solutions. We pass off substance abuse as someone else's problem, when in fact it touches all of us.

Even as we pigeonhole substance abuse, we are all paying its price. We pay in immediate ways — drunk-driving crashes, spousal and child abuse, street crime, family breakups — and not so immediate ways — higher medical costs, higher automobile insurance rates, increased workers' compensation and disability, more taxes for prisons and police, and reduced efficiency in the workplace.

The irony is that while science is pointing us one way, we are moving in the opposite direction. Virtually everyone directly involved in seeking to reduce substance abuse — doctors, treatment providers, police, judges, community activists — believes that treatment is the most effective and economic solution. Abundant evidence substantiates this belief.

THE DEADLIEST DRUG: Maine's addiction to alcohol

"Maine's alcohol plague can be addressed, but it will take a commitment to provide comprehensive treatment programs, and community participation."

In 1997, reporters for the Portland Herald Press and Maine Sunday Telegram investigated the effects of alcohol abuse in their state. They interviewed doctors, lawyers, criminals, mothers, children, drunk driving victims and offenders and experts. They reviewed data, alcohol studies, police and court records, medical journals, emergency room statistics, and death records. The result was an 8-day series entitled "The Deadliest Drug: Maine's Addiction to Alcohol." The series began with the entire Sunday front page devoted to substance abuse stories (10/19/97 edition); the rest of the series continued with front page placement, and concluded with articles on treatment.

www.portland.com/alcohol

Endnotes

i "Three Headed Dog From Hell: The Staggering Public Health Threat Posed By AIDS, Substance Abuse and Tuberculosis," Joseph A. Califano, The Washington Post, Dec. 21, 1992.

ii Preliminary Estimates From The 1995 National Household Survey On Drug Abuse, Substance Abuse and Mental Health Services Administration, U.S. Dept. of Health and Human Services, 1996.

iii "Three Headed Dog," ibid.

iv Preliminary Estimates, ibid.

v "Costs of Untreated Substance Abuse to Society," Constance M. Horgan, Sc.D., The Communique, Spring 1995, Center for Substance Abuse Treatment, U.S. Department of Health and Human Services. Also: Dorothy P. Rice, Sander Kelman, Leonard S. Miller, and Sarah Dunmeyer, The Economic Costs of Alcohol and Drug Abuse and Mental Illness: 1985, report submitted to the Office of Financing and Coverage Policy of the Alcohol, Drug Abuse and Mental Health Administration (San Francisco: Institute for Health & Aging, University of California, U.S. Department of Health and Human Services, 1990).

vi Testimony of Melanie Whitter, Deputy Director, Policy, Planning and Evaluation Division, Illinois Department of Alcoholism and Substance Abuse, Join Together public hearing, May 13, 1997, Chicago, IL.

vii Testimony of Larry Meredith, Deputy Health Commissioner, Director of Substance Abuse Services, City of San Francisco, Join Together public hearing, May 13, 1997, Chicago, IL.

viii Making Welfare Reform Work: Tools for Confronting Alcohol and Drug Abuse Problems Among Welfare Recipients, The Legal Action Center, September, 1997.

ix Report available early 1998 on Institute of Medicine web page (www.nas.edu)

x "A Matter of Just Treatment: Substance Abuse and the Courts," Final Report, Supreme Judicial Court Substance Abuse Project Task Force, March, 1995.

xi Keeping Score 1996, Drug Strategies, Washington, D.C., 1996.

xii The National Treatment Improvement Evaluation Study, SAMSHA, Dept. of Health & Human Services, Center for Substance Abuse Treatment, 1996.

xiii Center for Substance Abuse Treatment and the National Evaluation Data and Technical Assistance Center, cited in CSAT By Fax, Nov. 29, 1995.

xiv Enhancing Drug Treatment: Evaluation of the Los Angeles Target Cities Project, Robert Fiorentine and M. Douglas Anglin, UCLA Drug Abuse Research Center, 1996.

xv Drug Use Forecasting, Annual Report on Adult and Juvenile Arrestees 1995, National Institute of Justice.

xvi Mandatory Minimum Drug Sentences: Throwing Away the Key or the Taxpayers' Money? Jonathan P. Caulkins, C. Peter Rydell, William L. Schwabe, and James Chiesa, RAND Corporation 1997.

xvii Controlling Cocaine: Supply Versus Demand Programs, RAND Corporation, Drug Policy Research Center, 1994.

xviii Gerstein, D.R., Johnson, R.A., Harwood, H., Fountain, D., Suter, N., and Malley, K., Evaluating Recovery Services: The California Drug and Alcohol Treatment Assessment, General Report. Submitted to the State of California Dept. of Alcohol and Drug Programs; Chicago; National Opinion Research Center, 1994.

xix James A. Swartz, Ph.D., Arthur J. Lurigio, Ph.D., and Scott A. Slomka, "The Impact of IMPACT: An Assessment of the Effectiveness of the Cook County Jails Substance Abuse Treatment Program," Chicago, Illinois, 1994.

xx Commonwealth Marketing and Development, Client Treatment Follow up Study, Portland, Maine; Office of Substance Abuse, 1994.

xxi See note # xvii.

xxii See note # xviii.

xxiii See note # xvii.

xxiv Testimony of Steve Allen, Ph.D., Director, Chemical Dependence Services, Kaiser Permanente, Vallejo, Calif., Join Together public hearing, May 13, 1997, Chicago, IL.

xxv See note # xviii.

xxvi See note # xviii.

xxvii McCarty, Dennis, Institute for Health Policy, Brandeis University, "Managed Care for Substance Abuse Services," prepared for Drug Strategies, Washington, DC, January 1996.

Treatment Resources

Organizations

Federal Agencies:

Center For Substance Abuse Treatment (CSAT)
5600 Fishers Lane
Rockwall II Building
Rockville, MD 20857
(301) 443-2467
www.samhsa.gov/csat.htm
CSAT seeks to expand the availability of effective treatment and recovery services for substance abusers; improve the quality of services aimed at special populations vulnerable to addictive disorders; improve coordination among health/mental health providers/entities and social service providers/agencies; and upgrade publicly funded addiction treatment and recovery programs.

CSAT's Target Cities Program is a national demonstration program that implements model infrastructures to coordinate and enhance localtreatment options. Contact CSAT's Division of National Treatment Demonstations at (301) 443-7745.

Treatment Works! September is 'Treatment Works! Month.' This DHHS/CSAT campaign focuses on getting the word out that treatment is effective. CSAT's National Drug and Alcohol Treatment Referral Service: 1-800-662-HELP.

Addiction Technology Transfer Centers
CSAT, Office of Scientific Analysis and Evaluation
Rockwall II Building, 10th Floor
5600 Fishers Lane
Rockville, MD 20857
(301) 443-8521
www.views.vcu.edu/nattc/
The Addiction Technology Transfer Center Program maintains a national network of centers for the purpose of improving the skill level of addiction treatment practitioners in a variety of disciplines.

National Clearinghouse for Alcohol and Drug Information
P.O. Box 2345
Rockville, MD 20847-2345
(800) 729-6686
www.health.org
The National Clearinghouse for Alcohol and Drug Information (NCADI) is the information service of the Center for Substance Abuse Treatment. NCADI is the world's largest resource for current information and materials concerning substance abuse.

National Institute On Drug Abuse
5600 Fishers Lane
Parklawn Building, Room 10-A39
Rockville, MD 20857
(301) 443-6245
www.nida.nih.gov
The mission of the National Institute on Drug Abuse (NIDA) is to lead the Nation in bringing the power of science to bear on drug abuse and addiction. NIDA is part of the US Dept. of Health & Human Services.

Non-Governmental Organizations:

Al-Anon and Alateen
1600 Corporate Landing Parkway
Virginia Beach, VA 23454
(757) 563-1600
www.al-anon.org
Provides hope and help for families and friends of alcoholics.

Alcoholics Anonymous
2480 South Main Street, Room 112
Salt Lake City, UT 84115
(801) 484-7871
www.aa.org
Alcoholics Anonymous is a fellowship of men and women who share their experience, strength and hope with each other that they may solve their common problem and help others to recover from alcoholism.

American Society of Addiction Medicine
4601 North Park Avenue, Arcade Suite 101
Chevy Chase, MD 20815
(301) 656-3920
www.asam.org
The nation's medical specialty society dedicated to educating physicians and improving the treatment of individuals suffering from alcoholism or other addictions.

ASAM offers Patient Placement Criteria for the Treatment of Substance-Related Disorders, Second Edition (ASAM PPC-2). Presented are six levels of primary assessment areas to be evaluated in making treatment and placement decisions settings for adults with chemical dependencies. A CD-ROM version of the PPC-2 is currently under development.

Center on Addiction and Substance Abuse
152 West 57th Street, 12th Floor
New York, NY 10019
(212) 841-5200
www.casacolumbia.org
A resource for research on addiction and substance abuse. It provides access to information, research and commentary on tobacco, alcohol and drug abuse issues including prevention, treatment and cost data.

Delancey Street
2563 Divisadero Street
San Francisco, CA 94115
(415) 957-9800
Delancey Street is a model that is neither a halfway house nor an after care program. There is no drug treatment — all residents must be drug free while they live on the premises. However, all residents are former substance abusers or ex-convicts. Upon coming to Delancey Street, they are given a haircut and a new set of clothes, and they must work in one of the house's many enterprises, including a popular San Francisco restaurant.

Hazelden
P.O. Box 11, CO3
Center City, MN 55012-0011
(800) 257-7810
www.hazelden.org
Hazelden, a nonprofit organization, provides residential and outpatient treatment for adults and young people, programs for families affected by alcoholism and other drug addiction, and training for a variety of professionals. Also publishes information on the topics of alcoholism, drug addiction, and related areas.

Legal Action Center
236 Massachusetts Ave., NE
Suite 505
Washington, DC 20002
(202) 544-5478
Email: lacinfo@lac.org
The Legal Action Center advocates for expanding substance abuse treatment and prevention services, and fighting discrimination against people who are in recovery or suffering from alcoholism, drug dependence, or HIV/AIDS.

National Acupuncture Detoxification Association
3220 North Street, NW, Suite 275
Washington, DC 20007
(503) 222-1362
www.acupuncture.com
NADA was formed in 1985 to support the use of acupuncture in the treatment of chemically dependent persons.

National Alliance for Model State Drug Laws
33 Fairfax Street, Suite 201
Alexandria, VA 22314
(703) 836-6100
www.natlalliance.org
The National Alliance for Model State Drug Laws mission helps states effectively address alcohol and other substance abuse issues through effective use and coordination of enforcement, treatment, education, prevention, community and corrections resources.

National Alliance of Methadone Advocates
435 Second Avenue
New York, NY, 10010
(212) 595-NAMA (6262)
www.methadone.org
The National Alliance of Methadone Advocates educates the public (as well as treatment providers about (and promotes) quality methadone maintenance treatment as the most effective modality for the treatment of heroin addiction. It fights discrimination and stigmatization against methadone patients. Its membership is made up of both patients and supporters of quality methadone maintenance treatment.

National Association for Children of Alcoholics
11426 Rockville Pike, Suite 100
Rockville, MD 20852
(301) 468-0985
www.health.org/nacoa
An advocate for all children and families affected by alcoholism and other drug dependencies. Offers programs and materials to help children of alcoholics.

National Association of Addiction Treatment Providers
501 Randolph Drive
Lititz, PA 17543-1901
(717) 581-1901
www.naatp.org
The National Association for Addiction Treatment Providers raises public awareness of addiction as a treatable disease, promotes the highest standards of addiction treatment, and secures reimbursement for treatment programs.

National Association of Alcoholism and Drug Abuse Counselors
1911 Fort Myer Drive, Suite 900
Arlington, VA 22209
(703) 741-7686
www.naadac.org
NAADAC, established in 1972, is a professional membership organization composed of counselors, educators, administrators, and other health care givers, all of whom work in the field of alcoholism and drug abuse. NAADAC represents 40,000 professional counselors employed in the treatment and care of chemically dependent persons.

National Association of State Alcohol and Drug Abuse Directors
(NASADAD)
808 17th St., NW
Suite 410
Washington, DC 20006
(202) 293-0090
www.nasadad.org
NASADAD is the membership organization for state and alcohol and drug abuse agency directors. It works with national organizations and federal agencies to foster comprehensive substance abuse program capabilities in each state.

National Council on Alcoholism and Drug Dependence
12 West 21 Street
New York, NY 10010
(212) 206-6770
www.ncadd.org
NCADD provides education, information, help and hope in the fight against the chronic, often fatal, disease of alcoholism and other drug addictions.

National Helplines of Phoenix House (operated by the American Council for Drug Education of NY)
164 West 74th Street
New York, NY 10023
(212) 595-5810, X7580
(800) DRUGHELP
www.drughelp.org
The National Helpline is a toll free, national substance abuse information and referral service. It provides information on specific drugs and treatment options; and referrals to treatment prgrams,self help groups,family support groups, and crisis centers nationwide.The Helpline is the only 24-hour-a-day nation wideconfidential helpline dedicated exclusively to providing callers throughout theU.S. with information on and referrals to sustance abuse treatment.

National Organization on Fetal Alcohol Syndrome
1815 H St., NW, Suite 710
Washington, DC 20006
(202) 785-4585
www.nofas.org
NOFAS is dedicated to eliminating birth defects caused by alcohol consumption during pregnancy and improving the quality of life for those individuals and families affected.

National Oxford House, Inc.
P.O. Box 179
Great Falls, VA 22066
(703) 450-6501
www.icagroup.org
Oxford Houses are a sober living housing option for clients.

National Technical Center for Substance Abuse Needs Assessment
875 Massachusetts Avenue, 7th Floor
Cambridge, MA 02139
(617) 864-9115
The National Technical Center for Substance Abuse Needs Assessment assists states in developing appropriate methodologies, integrating various data sets, and searching for technical information. The NTC provides technical assistance through workshops, periodic technical bulletins, a library of needs assessment documents, the expertise of its steering committee, and a series of technical manuals. Two primary aspects addressed in the assessment are: How many persons need help in overcoming substance abuse, and what services do they need to overcome their addictions? The Center began its activities in Sept., 1992.

National Treatment Consortium
P.O. Box 1294
Washington, DC 20013
(202) 434-4780
www.ntc-usa.org
NTC is an organization designed to address the challenging issues and initiatives of the delivery, purchase and payment of treatment for addictions and mental illness. NTC's mission is to create and perpetuate ongoing dialogue between payers, purchasers, providers, and the public in an effort to enhance the nation's treatment capacity and improve the accessibility to quality care.

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National Women's Resource Center
515 King St., Suite 410
Alexandria, VA 22314
(800) 354-8824
www.nwrc.org

The National Women's Resource Center's mission is to provide information around the prevention and treatment of alcohol, tobacco, other drugs, and mental illness in women. The organization is continuing the work of CSAP's Resource Center for the prevention of perinatal abuse of alcohol and other drugs. In addition, the center provides publications lists, service referrals, and an electronic bulletin board service.

Therapeutic Communities of America
Linda Wolf Jones, Executive Director
1818 N St., NW
Suite 300
Washington, DC 20036
(202) 875-8636

Therapeutic communities are long known for addressing the needs of "hard core" substance abusers, those with long drug using histories, criminal backgrounds, who lack education and vocational skills and family support networks. TCs have grown from their residential program bases to include outpatient services, day treatment, crisis intervention, family therapy, case management, education, prevention, and relapse prevention.

U.S. Conference of Mayors
1620 Eye Street, NW
Washington, DC 20002
(202) 293-7330
www.mayors.org

The United States Conference of Mayores is the official nonpartisan organization of cities with populations of 30,000 or more. Collectively, Conference of Mayors members speak with a united voice on matters pertaining to organizational policies and goals. Individually, each member mayor contributes to the development of national urban policy.

Women For Sobriety
P.O. Box 618
Quakertown, PA 18951-0618
(215) 536-8026
www.mediapulse.com

Women For Sobriety, Inc. is a non profit organization dedicated to helping women overcome alcoholism and other addictions.

Additional Treatment Websites

Addiction Resource Guide — www.hubplace.com/addictions
A comprehensive directory of addiction treatment facilities online.

Alcohol & Drug Services Homepage — www.shopthenet.net
This site includes information on education, prevention, treatment, and judicial services; a list of national 1-800 phone lines for addiction and substance abuse information; prevention information and tips; and links to related sites.

American Cancer Society — www.cancer.org
The American Cancer Society sponsors the Great American Smokeout and provides help for smokers who want to quit.

Betty Ford Center — www.bettyfordcenter.com
Provides effective alcohol and other drug dependency treatment services to help women, men and families begin the process of recovery.

CAAS Treatment News — www.jointogether.org/JTO/community/treatment.html
News on the nicotine addiction treatment front from the Center for Alcohol and Addiction Studies at Brown University.

Cocaine Anonymous — www.ca.org
Cocaine Anonymous is a fellowship of men and women who share their experience, strength and hope with each other so that they may solve their common problem and help others to recover from their addiction.

Community Services Information Center — www.csic.com
National online referral center for substance abuse treatment centers, therapists, and other resources.

Great American's Drug Free Workplace Program — www.gaic.com
Great American provides assistance to workers' comp customers in adopting Drug-Free Workplace Programs.

Internet Alcohol Recovery Center — www.med.upenn.edu/~recovery
The internet Alcohol Recovery Center is a Treatment Research Center sponsored by the University of Pennsylvania. It provides a community center, online libraries, and directories of clinics and support groups.

Intervention Center — www.intervention.com
A resource for families and organizations dealing with someone involved in alcohol, drugs, or some other self-destructive behavior.

Narcotics Anonymous — www.wsoinc.com
Narcotics Anonymous is an international, community-based association of recovering drug addicts.

QuitNet — www.quitnet.org
The QuitNet provides tools and information for both people seeking to quit smoking, as well as professionals in the medical and tobacco control fields.

Research Institute on Addictions — www.ria.org
The Research Institute on Addictions (RIA) in Buffalo, NY, is a national leader in alcohol and substance abuse prevention, treatment, and policy research.

SAMHSA's National Directory of Drug Abuse and Alcoholism Treatment and Prevention Programs — www.health.org/daatpp.htm
This database provides a listing of Federal, State, local, and private providers of alcoholism and drug abuse treatment and prevention services.

The Dual Diagnosis Pages — www.monumental.com
A forum and document resource center for professionals working in the dual diagnosis arena.

The Treatment Improvement Exchange — www.treatment.org
The Treatment Improvement Exchange (TIE) is a federal resource sponsored by the Center for Substance Abuse Treatment to provide information exchange between CSAT staff and State and local alcohol and substance abuse agencies.

UCLA Drug Abuse Research Center — www.mednet.ucla.edu
The Drug Abuse Research Center (DARC) is a diverse research organization that investigates psychosocial and epidemiological issues pertaining to drug use and conducts evaluations of interventions for drug dependence.

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Appendix I

Treatment Glossary

Addiction — a progressive, chronic, relapsing brain disease that involves compulsive substance (drug, alcohol, or tobacco) — seeking behavior and loss of control, despite negative physical, mental, and social consequences. Addiction is the result of increased dopamine (a chemical related to the 'high' feeling) levels creating fundamental changes in the pathways of the brain. Alcohol, cocaine and heroin all increase dopamine levels and seem to affect the brain pathways in the same way.

Aftercare — for the purposes of this report, aftercare refers to the social (education, housing assistance, counseling, daycare, employment or vocational training, etc.) and health care services, including continued treatment, helpful in sustaining recovery. Aftercare, considered necessary to prevent relapse, also includes 12-step meetings, periodic group or individual counseling, skills training, self-help, and relapse prevention strategies.

Biopyschosocial — a process or state which has (a) biological, medical, and possibly genetic factors; (b) pyschological and emotional factors; and (c) social, familial, cultural, and other environmental factors. Addiction, treatment, recovery and relapse are all biopyschosocial processes.

Detoxification — the counteraction or removal of the effects of chemical substances from the body. Detoxification is often conducted under the supervision of clinicians or treatment specialists.

Functional improvement — includes, but is not limited to, measures such as improved quality of life, increased employment stability, reduced family dysfunction, improved psychological functioning, reduced violent behavior, reduced criminal activity, and reduced likelihood of using substances again.

HEDIS — Health Plan Employer Data and Information Set is a report published by the National Committee for Quality Assurance. Managed care organizations report their health care outcomes and costs, and HEDIS compiles the results. Measuring tools vary among health care organizations, so data are not comparable across the managed care industry.

Independent treatment manager — a person who has case management and review authority, but no administrative or financial responsibilities or interests with respect to patient care or the health care system.

Parity — equality, as in amount, status, or value. Parity, as it relates to chemical dependency treatment and financing, requires insurers to offer the same health care benefits for chemical dependency as for other physical disorders and diseases.

Pharmacological treatment — medications for alcohol, tobacco and drug dependence may be utilized at a number of stages in the treatment process, from detoxification to long term maintenance. Several medications facilitate acute detoxification. Other medications are utilized to help prevent relapse to substance dependence. It is generally understood that the use of medication for substance abuse may be considered as part of a comprehensive treatment program.

Relapse — difficulty in avoiding substances due to biopsychosocial influences. Relapse is a common part of the recovery process and should not be viewed as a failure of treatment.

Substance use — defined as occasional alcohol, tobacco, or drug use and implies ingestion of substances for nonmedical purposes. Substance use is not classified as a medical disorder by the major diagnostic criteria tools, DSM-IV (Diagnostic and Statistical Manual of Mental Disorders) or ICD-10 (International Classification of Diseases).

Substance abuse — defined by DSM-IV as regular, sporadic or intensive use of higher doses of drugs, alcohol or tobacco leading to social, legal or interpersonal problems.

Substance dependence (addiction) — defined as uncontrollable substance-seeking behavior involving compulsive use of high doses of one or more substances resulting in substantial impairment of functioning and health. Tolerance and withdrawal are characteristics associated with dependence.

Treatment — ideally, an organized, highly structured program with individual, group, and family therapy for addicted individuals. Treatment should include detoxification management of drug dependence, and prevention of relapse. Trained staff should conduct assessments of potential clients and refer them to the treatment best suited to meet each individuals' needs. Treatment modalities generally follow a continuum ranging from least intensive to very intensive, and treatment can be provided in a variety of different settings.

Treatment effectiveness — generally, three domains are important in judging the effectiveness of treatment: reduction in substance use including abstinence; improvement in personal health and social functioning; and a reduction in public health and safety risks.

Withdrawal — termination of the administration of an addictive substance, and the physiological readjustment that takes place upon such discontinuation.

Definition Sources:

Pathways of Addiction, Institute of Medicine, 1996;

Overview of Addiction Treatment Effectiveness, SAMHSA, revised 1997;

The American Heritage Dictionary, 2nd ed.;

Treatment Protocol Effectiveness Study, ONDCP, 1996;

Join Together Briefing Paper on Substance Abuse Treatment, 1997.

Treatment Modalities

Treatment Modalities — approaches proven to be effective in reducing substance abuse problems among individuals. Treatment plans for substance abusers often consist of various combinations of settings and modalities either simultaneously or sequentially. However, treatment approaches may be broadly categorized into five areas: pharmacological treatment (e.g., methadone maintenance); brief interventions; non-methadone outpatient; residential/hospital inpatient; and long-term residential. Also included are self-help programs such as Alcoholics Anonymous and Narcotics Anonymous.

12-Step Program — a type of self-help program based on a model of total abstinence. Certified counselors (often recovering addicts) conduct most of the group and individual counseling, with program staff providing consulting and resource backup as needed. Counseling is focused on family and other interpersonal relationships. Patients work on at least the first four steps of the AA model while in the treatment program, with progression through the remaining eight steps expected through subsequent involvement with AA or NA. Detoxification and health assessment also are included in 12-step programs. The Minnesota Model (patterned after the Hazelden program in Minnesota) is a type of 12-step program.

Brief Intervention — a less intensive clinical treatment in which a health care or substance abuse professional assesses, counsels or refers, and follows up with an individual who has a substance abuse problem. Several counseling sessions usually take place. Brief interventions are particularly effective for individuals who may not have previously been assessed as having a problem, or who may not be otherwise motivated to seek help.

Cognitive/Behavioral Approaches — emphasize identifying internal and external cues associated with cravings and relapse, and learning how to avoid them. The goal is to prevent a slip-up from becoming a full relapse. Common cognitive and behavioral approaches include group and individual therapy, social skills and self-control training, aversion therapies, stress management, and general education.

Halfway Houses — peer-group oriented, residential, treatment facilities aimed at helping clients gradually adjust to independent living in the community. They provide food, shelter, and supportive services, including vocational, recreational, and social services in a supportive, drug free environment. The prescribed length-of-stay usually ranges from 30 days to six months.

Inpatient Treatment — the treatment of drug dependence in a hospital and includes medical supervision of detoxification. Inpatient drug treatment programs traditionally last for 28 days, although this duration has changed considerably since the emergence of managed care models in substance abuse services and currently ranges from as little as three days to longer, more traditional lengths of stay. An example of this type of facility is the Betty Ford Clinic.

Methadone Maintenance Treatment — outpatient programs that offer treatment for dependence on opiates (usually heroin), in which addicts take oral doses of a synthetic opiate called methadone. Methadone is administered once a day and by eliminating the craving for heroin, it permits physiological stabilization without withdrawal symptoms in order to make recovery easier. LAAM, levo-alpha-acetylmethadol, is an alternative opiate substitution therapy. LAAM is a longer acting opioid and consequently requires less frequent clinic visits for maintenance. Methadone maintenance frees the client's energy and attention to address personal problems and behavior related to their addiction. Ideally, programs should offer referrals for treatment and aftercare services.

Outpatient Counseling Treatment — treatment programs that provide planned and structured individual, group and/or family counseling for abusers. This type of program allows people to work or attend school while recovering and learning to live drug-free. After initial assessment, programs may suggest only a few hours of counseling a week, while others are more comprehensive, with attendance required seven days a week.

Residential Treatment — supervised, 24 hour programs where clients live in a professionally-staffed facility with others in recovery. This modality is appropriate for clients who need a highly structured, secure environment to stay clean. These treatment facilities provide assessment, diagnosis, and comprehensive treatment for clients. The period of treatment in this environment varies and may last anywhere from 30 days to a year.

Social Community Recovery Houses — recovery houses provide a self-help, peer-supported recovery environment that incorporates the principles of AA and NA and reinforces behavior change over the long term. The average length of stay is just over one year, but there is not necessarily a time limit on how long a resident can stay. Each member contributes money to cover house expenses and has a democratic vote in removing those who return to drinking or drug use. Examples include Oxford House and Delancey Street (California).

Therapeutic Communities ('TCs') — intensive, long-term, highly-structured residential treatment modalities for chronic, hardcore drug users who have failed at other forms of drug abuse treatment. TCs use peer support, strong confrontation, counseling, and job training to rehabilitate clients. This type of treatment lasts longer than other modalities, from six months to over a year. It emphasizes self-help and often uses recovering addicts as staff counselors.

Appendix II

Physician Leadership on National Drug Policy Consensus Statement, July 9, 1997

A group of nearly 40 prominent doctors have recently joined together to focus attention on the problems of illicit drug use in America. The group, the Physician's Leadership on National Drug Policy, chaired by Dr. June Osborn, issued the following consensus statement in July 1997.

As physicians, we believe that:

- It is time for a new emphasis in our national drug policy by substantially refocusing our investment in the prevention and treatment of harmful drug use. This requires reallocating resources toward drug treatment and prevention, utilizing criminal justice procedures which are shown to be effective in reducing supply and demand, and reducing the disabling regulation of addiction treatment programs.
- Concerted efforts to eliminate the stigma associated with the diagnosis and treatment of drug problems are essential. Substance abuse should be accorded parity with other chronic, relapsing conditions insofar as access to care, treatment benefits, and clinical outcomes are concerned.
- Physicians and all other health professionals have a major responsibility to train themselves and their students to be clinically competent in this area.
- Community-based health partnerships are essential to solve these problems.
- New research opportunities produced by advances in the understanding of the biological and behavioral aspects of drugs and addiction, as well as research on the outcomes of prevention and treatment programs, should be exploited by expanding investments in research and training.

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Three Cities' Approaches to Advancing the Common Good

San Francisco's Treatment on Demand Initiative

In San Francisco, the Mayor and Board of Supervisors have made an historic commitment to make substance abuse treatment services available upon request to active drug users. Implementation of this mandate, known as Treatment on Demand (TOD), has been undertaken by the San Francisco Department of Public Health, Community Substance Abuse Services (CSAS) Division. A forty-member advisory board composed of community leaders, substance abuse and treatment providers, related service providers, consumers of these services, and representatives from the Department of Public Health and other city and county professionals, assisted CSAS in developing a strategic plan for TOD, the 'First Steps Plan.' The plan represents a departure from traditional models of treatment in its recognition that drug addiction treatment takes many forms, and that no single treatment strategy or orientation is effective for every individual who has a substance abuse problem.

CSAS is developing a variety of outreach, engagement, treatment and prevention approaches to deal with the pervasive substance abuse treatment problems. Treatment approaches included in the TOD plan are harm reduction, a family-centered approach, a client-centered approach, and abstinence. The plan emphasizes that substance abuse services must provide an integrated, comprehensive system of care. This care begins by identifying a person's substance abuse and related mental and physical health problems, continues by placing him or her into the appropriate harm reduction, risk reduction or treatment services, and follows up by providing aftercare services.

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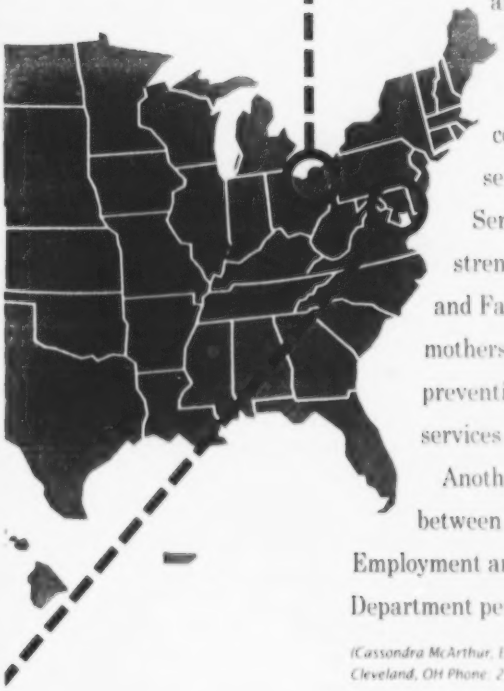
Baltimore's Treatment of Addiction

The City of Baltimore, Maryland, has introduced a program which treats addiction as a public health problem rather than a criminal problem. The city is using funding for treatment and prevention rather than law enforcement and incarceration. The plan includes an aggressive needle exchange program, job training, housing aid and other social programs for recovering persons. In addition, the program will direct addicted offenders into treatment through a drug court and a new "community court."

Cleveland CARES: Transitioning from Welfare to Work



Cleveland CARES Plus is a model program developed by the Alcohol and Drug Abuse Services (ADAS) Board of Cuyahoga (OH) County in response to county welfare reform plans. This centralized approach provides not only alcohol and other drug assessment and care management, but it addresses the acute and continuing care needs of the TANF (Temporary Assistance to Needy Families), or welfare population.

The major goals of the proposed program are to: improve access to comprehensive AOD assessments and referrals to primary treatment services; service enhancement and capacity building of the Alcohol and Drug Abuse Services system to reduce waiting lists for mothers needing treatment; strengthen joint treatment planning between the Ohio Department of Children and Family Services, caseworkers and the ADAS system clinicians working with mothers and their children; and augment continuing care services (relapse prevention strategies) via care plan linkages to other ancillary and supportive services needed to support mothers in recovery.

Another aspect of the program, JOBS/CARES Plus, is a collaborative effort between the Board of County Commissioners through the Ohio Department of Employment and the ADAS Services Board. Its initial purpose is to train Employment Department personnel to identify substance abuse barriers to job readiness and placement.

(Cassondra McArthur, Executive Director, Alcohol & Drug Addiction Services Board of Cuyahoga County, Cleveland, OH Phone: 216-348-4839)

In 1998, the city will spend $27 million to incorporate more than 3,000 additional treatment slots, including more intensive outpatient programs and three times as many residential beds, into their existing program. These residential programs can cost as much as $11,000 a year, whereas jail cells can cost $25,000 a year. By increasing the spending on treatment slots, wait lists as long as four months should be cut to weeks.

(The Boston Globe, Nov. 12, 1997; Andrea M. Evans, Executive Director, Baltimore Substance Abuse Systems, Inc., Phone: 410-637-1900)

Steps to Convene a Local Policy Panel

For additional information on public policy panels, contact:

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Policy panels are effective tools to generate awareness of substance abuse problems among public officials and citizens. They can also lay the foundation for developing a community-wide strategy and help advance already defined strategies. Below is a six-step process used by Join Together National Public Policy Panels which can be adapted by local and state policy panel conveners.

Panels offer community residents an opportunity to ask how they want to change, what they want the change to be, and what needs to happen for the change to occur.

1. **Select key leaders in the community to chair and serve on the panel.**
   Ensure that they represent expertise as well as awareness of the community. In addition to substance abuse advocates, look for talent and support in every aspect of the community. Involve public officials at the earliest opportunity.

2. **Outline the mission of your panel.**
   State your goals so the panel members, especially the chair, understand what is expected of them.

3. **Hold a public hearing as part of the process of preparing the panel recommendations.**
   Select informed and credible witnesses representing varying points of view. Include recovering people to tell how treatment has helped them, their families, and their workplace productivity.

4. **Prepare and release the final report.**
   This is a further opportunity to network with key constituencies. Include examples to illustrate how the recommendations can be implemented, and cite local and national resources.

5. **Monitor the implementation of the final recommendations.**
   This phase of the policy panel activity can include a progress report, report cards and success stories based on the fulfillment of the panel's proposals.

6. **Use each of the above steps to attract media attention to the issue.**
   Your media strategy might include editorial board meetings and broadcast talk programs. The panel chair and members are instrumental in these settings, as well as in legislative hearings and civic meetings. These are also opportunities to reinforce existing relationships and recruit new allies.

Action Steps

- Use this report as an opportunity to schedule a meeting with elected and appointed officials in your community, as well as with candidates for local offices. Tell them what you would like them to do to increase treatment and recovery opportunities for people addicted to alcohol and other drugs. Tell them why this is part of a coordinated effort to prevent and reduce the abuse of alcohol and other drugs in your community. Leave a copy of the report with them.

- Link with others throughout your legislative district and state to sponsor special events with members of Congress, legislators and other state officials. Use these events to let recovering people tell their stories, and to provide information that explains the benefits and efficacy of treatment.

- Use this report to reach out to others who may not be active in the community's efforts to reduce substance abuse, such as fraternal and civic organizations, schools, businesses, justice system officials, health care providers, and others. Describe the impact of effective treatment on your community. Work with them to establish common goals.

- Convene a town meeting to discuss the issues raised in this report. Ask participants what they want done about substance abuse in your community. Ask a local cable television operator to televise the meeting so residents who were unable to attend can still benefit from the content.

- Convene a local policy panel to make recommendations that meet your community's treatment needs. Involve public officials, local opinion leaders, recovering people, family members of people in treatment, and others throughout the community. Hold a public hearing to listen to experts and others concerned about treatment and recovery.

- Schedule meetings with newspaper editorial boards and local broadcasters. Brief them on how substance abuse is affecting your community, and the role treatment plays in reducing these harms. Make recommendations for change.

- Circulate this report to others in your community concerned about alcohol and drug abuse.

- Treatment for alcoholism and other drug addiction must be covered as a health benefit on an equal basis with treatment for other diseases.

- Limited access to treatment for alcoholism and drug addiction is a national crisis that calls for a broad based, national campaign to educate the public and build political support.

- Expand research on the nature and treatment of substance abuse and recovery. Make the results more promptly and easily accessible to professionals, policy makers and the public.

- Require education and training on the nature of addiction and the recovery for all health, mental health, social service and justice system professionals.

- Treatment for alcoholism and drug addiction must be monitored by independent treatment managers with no vested financial interests in order to ensure ongoing treatment effectiveness.

- Diagnosis, treatment and long term recovery must be integrated into a coordinated, community-wide strategy to reduce alcohol and other drug problems. This strategy should encompass economic development, health and mental health care, the justice system and other key institutions.

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About Join Together

Join Together is a national resource for communities fighting substance abuse and gun violence.

Join Together initiatives include:

- Award winning websites. Join Together Online (www.jointogether.org) connects people across the country electronically to share successful strategies and provides the latest information on substance abuse and gun violence prevention. The QuitNet (www.quitnet.org) gives smokers and tobacco control professionals access to interactive quitting tools, peer to peer support, news and information.
- Public policy panels to help communities identify and overcome policy barriers that hamper their ability to reduce substance abuse.
- A communications strategy to keep the issue of substance abuse on the national agenda, and to help local groups articulate the link between substance abuse and other social problems in their communities.
- Technical assistance to answer questions from community groups as they develop a comprehensive strategy to address substance abuse and gun violence.
- National surveys which describe and quantify the community movement against substance abuse.
- National Leadership Fellows Program to recognize outstanding community leaders and provide them with training opportunities to enhance their leadership skills and knowledge about substance abuse.
- National Program Office for Fighting Back. 14 communities which have comprehensive strategies to reduce substance abuse and the related harms.

Join Together is primarily funded by The Robert Wood Johnson Foundation through a grant to the Boston University School of Public Health. The gun violence prevention website is supported by funds from the Joyce Foundation.

Visit Join Together's websites at:

www.jointogether.org

www.quitnet.org

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